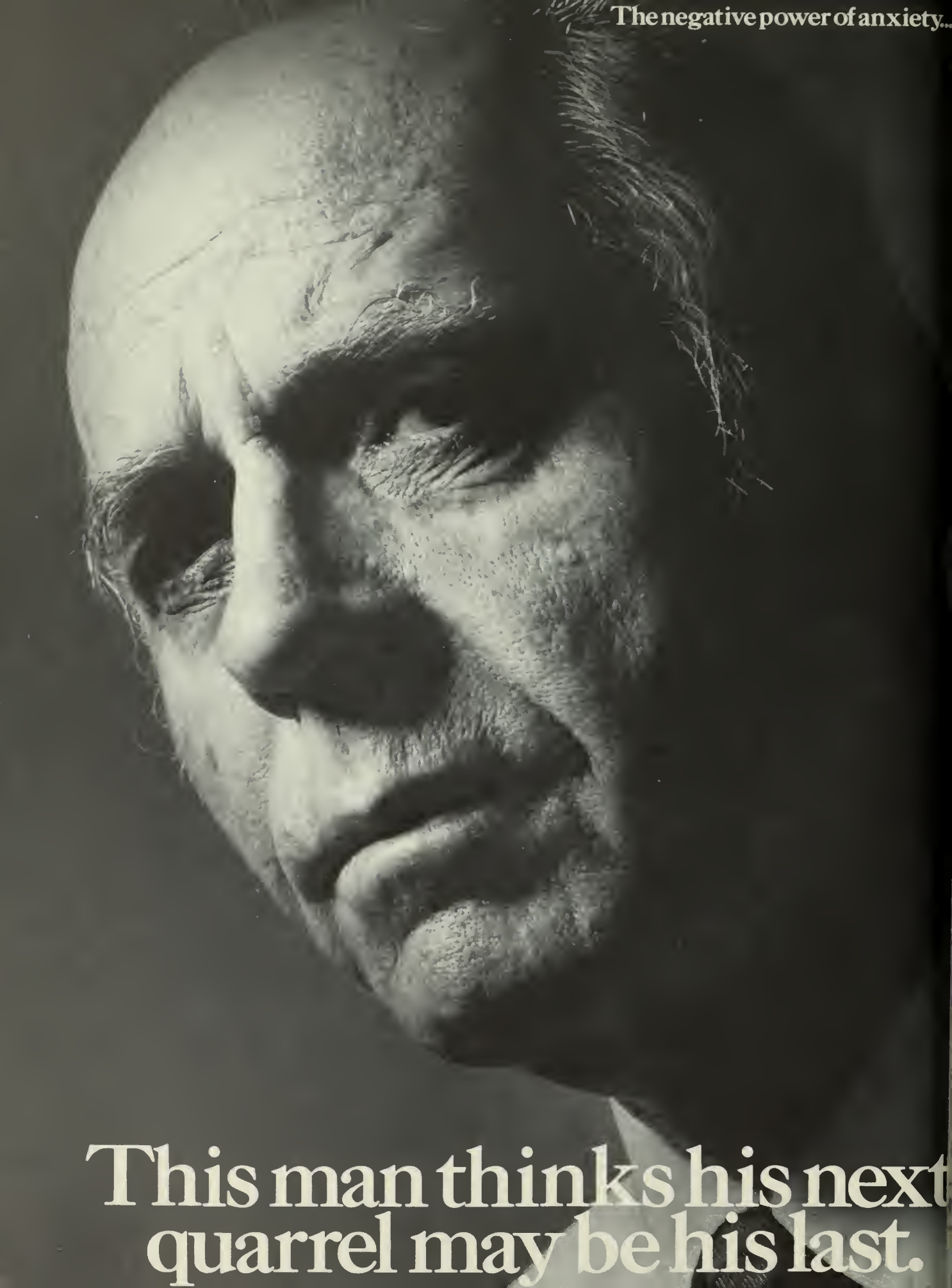
HARVARD MEDICAL ALUMNI BULLETIN

November / December 1971

The negative power of anxiety...



This man thinks his next quarrel may be his last.

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Libritabs (chlordiazepoxide) permits flexible, individualized therapy through its three oral dosage strengths.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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The opinions of contributors to the Bulletin *do not necessarily reflect those of the Editorial Staff.*

Choice, Fees, and Quality

by Rolf Lium '33

In the present political climate of the United States, adequate medical services for the entire population are considered as much of a right as is free education. Medical care is thus defined as an obligation that the state owes to its citizens regardless of their ability to pay and irrespective of where they live. In the history of medicine there have evolved what physicians have come to regard as their "property rights." Quite simply, they are:

The patient to have a free choice of physician.

Fee-for-service.

The physician to be the sole arbiter in deciding how to handle his patient.

It is in the best tradition of the American system to re-examine our standards and decide if practices developed in earlier agrarian times are capable of solving the problems of a highly complex, industrialized society. Thus came about our antitrust laws, the regulation of utilities, changes in concepts of education, and revision of our banking and security codes.

Free Choice of Physician

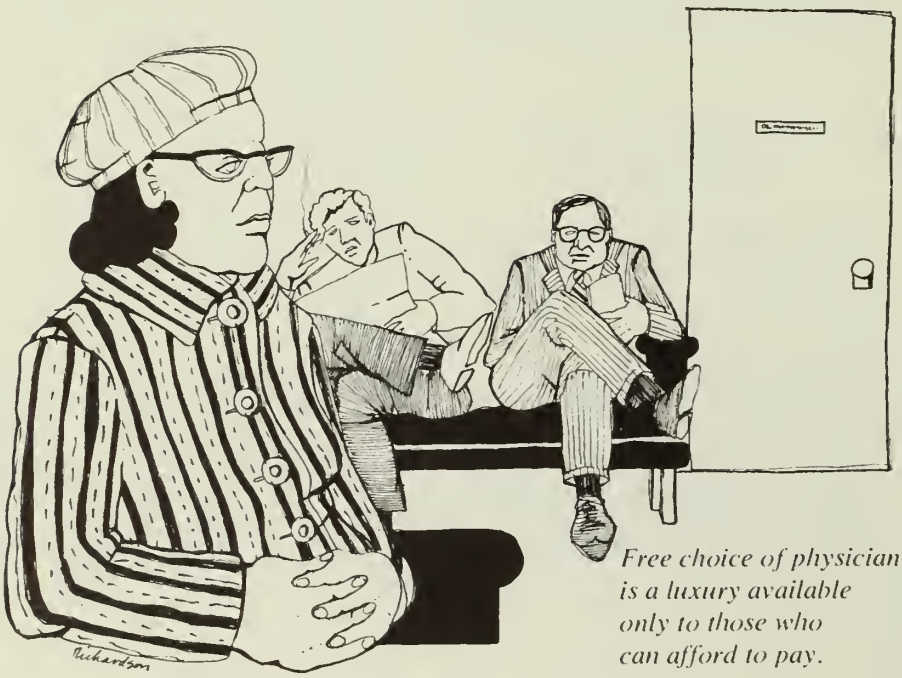
Anyone who has had experience in the outpatient clinic of a large metropolitan hospital recognizes the absurdity of "free choice" as a criterion for medical services. The patients seen in these institutions not only have no choice, but are fortunate to be seen by any visit, resident, intern, medical student, or even nurse. In the American system of medical care, "free choice of physician" has always been a luxury available only to those who could afford to pay. It is sheer nonsense as a concept when one considers large segments of our population such as migrants, Indians, and inner-city groups where no physician is available. To have care when one needs it is the issue at stake for the medically dispossessed, not a selection among competing facilities or professionals. However, the abolition of "free choice" as a cornerstone of American medicine does not imply that those who wish to indulge themselves in this luxury should not continue to do so.

Fee-for-Service

In the development of a National Health Service, such as our country is now embarking upon, fee-for-service will be the greatest stumbling block in an effort to fashion a basic agreement between the profession and government. A study of the experience in other countries leads one to conclude that fee-for-service constitutes an historical imperative; furthermore, a strict fee-for-service system and a total health service are mutually exclusive, for one principle reason.

Fee-for-service is possible in episodic illness such as surgical procedures, single laboratory tests, and a house call, but much of total medical care falls outside this category. Preventive medicine, to be effective, must deal with large segments of population, an endeavor best accomplished through an organized service. Many categories of disease are best handled by regionalization of effort in the interest of efficiency and high standards of care. Dialysis and transplantation for end-stage kidney disease can only be furnished in a setting where many disciplines cooperate to give a total service. Another instance is spinal cord injury, where it has been demonstrated in other countries that a single center for an area the size of New England is far superior to a splintered system of care such as now exists in this region for civilians on a fee-for-service basis. By comparison, the non-fee-for-service Veteran's Administration provides patients excellent comprehensive care.

The outstanding flaw in a fee-for-service system is that it lends itself to excessive services in the form of over-diagnosis, over-hospitalization, over-operating, and unneeded calls. The evidence elicited by Senator Long's committee to investigate the abuses of Medicare and Medicaid is eloquent testimony of how a plan that could only work with full cooperation of an honest profession, has been almost destroyed by the unscrupulous exercise of fee-for-service.



Free choice of physician is a luxury available only to those who can afford to pay.

The relatively common operations of abdominal hysterectomy and tonsillectomy are performed four times as often in New England community hospitals (fee-for-service) as in Sweden (non-fee-for-service).[1] The same source reveals that mastectomy is done in New England three times as commonly as in Sweden although the incidence and mortality for mammary cancer are the same in the two countries.

In a National Health Plan the physician plays the same role as the teacher in an educational system; both are specialists in providing a service to the entire population. Let us imagine that a teacher was paid on a sliding scale of results:

$5.00 for each A given a pupil
$3.00 for each B
$2.00 for a C
$0.00 for a flunk

It is better than an even wager that the number of brilliant pupils would rise steeply. The important consideration in developing a health service is that it must be fairly and impartially applied and not subject to the whims of those who execute it. Any arrangement where a fee-for-service can benefit a teacher or physician is subject to manipulation and corruption. The best example of this in modern medicine is:

The Monopolistic Specialists

The Board of Trustees of an institution contract with physicians to furnish all of the services in radiology, pathology, and anesthesia in a hospital. Competition in these specialties is thus eliminated and a monopoly established. The growth of services rendered by these three disciplines has led to enormous increases in volume, and one would think that in view of the monopoly, some arrangement of salary would be acceptable. Here organized medicine, in the form of specialist groups and societies, has managed to by-pass

Fee-for-service will be the greatest stumbling block in fashioning a basic agreement between the profession and government.

the property right of "free choice" while insisting with a vengeance on fee-for-service. Far from lowering their fees for individual cases, the monopolists, because of the increased volume, introduced an innovation direct from the marketplace — the technician.

A medical technician may be defined as a person who is taught to carry out limited procedures according to the strict rules of correct scientific method. It is amazing how much of modern medicine can be delegated to the technical forces of the medical team. Thirty years ago no one but a physician could place a needle in a patient's vein; now there are IV nurses who are so technically proficient that few doctors can equal their performance. By paying the technician a low salary and charging the regular fees, the monopolists are in the game of what manufacturers call mass production.

This is not a plea to abolish the technician, but rather to use him wherever possible to spare the physician the drudgery of lesser tasks. The gain for such economies in time and effort should be passed on to the public, and not to the pockets of monopoly.

Why should anyone believe that physicians as a group are better prepared ethically or morally than teachers, druggists, plumbers, or politicians to handle such a privilege as fee-for-service without abusing it? One must remember that the ability to absorb knowledge and develop special skills has nothing to do with character. The Internal Revenue operates on a law derived from long experience with the human condition: people are inclined to cheat as the rewards for cheating increase. All of the unctuous protests of the medical profession to the contrary, the fee-for-service can be and is used as a cover for malfeasance that should no longer be permitted to tempt the weak or the strong characters in medicine.

Self-Responsibility

In dealing with the property right of a physician to be the sole arbiter of his professional conduct, one introduces the consideration of quality in medical service, a very touchy subject, and capable of arousing anything from wounded pride to haughty disdain. The battles that have been and are being fought in this area of medical service have left few practitioners unscarred. Let us return to an early scene in the drama of judging medical care by its end results.

Dr. Emery Codman was a junior

[1] Hospital Caseloads. An International Comparison. Björn Smedley et al, Lancet, September 7, 1968, p. 559.

surgeon working in the outpatient department of the Massachusetts General Hospital, and in this capacity saw the tragic results of operations that the surgeons were claiming to be curative. Codman's message was quite simple — there must be some method for evaluating results in order to judge the effectiveness of a treatment. This called into question the performance of everyone from the Chief Surgeon to the house pupil. At the Massachusetts General, seniority prevailed as a concept in promotion. The Chief could do no wrong; he was the law.

Codman was of that breed that can become righteously indignant and respond to opposition by a crusade. He pressed his point on the national stage, for he knew that he was right, and in his Puritan conscience he didn't give a damn what anyone thought; he would win his battle. That this brilliant and eccentric performer was not a diplomat is shown in the cartoon that he had drawn for the presentation of his ideas to the Boston Medical Society, which is reproduced below. This made his cause all the more difficult, for he antagonized many who might have been sympathetic to his ideas.

Codman was villified, demoted, and forced from his appointment, but he won his case, and today the evaluation of care by study of end results is basic to the practice of good medicine.

If the battle for evaluation of quality in medical service was fought with such a toll in a venerable and honorable institution of American medicine that boasts a central building by Bulfinch and an amphitheatre where ether was first used, what can one expect when one reaches into the hinterland of the community hospital?

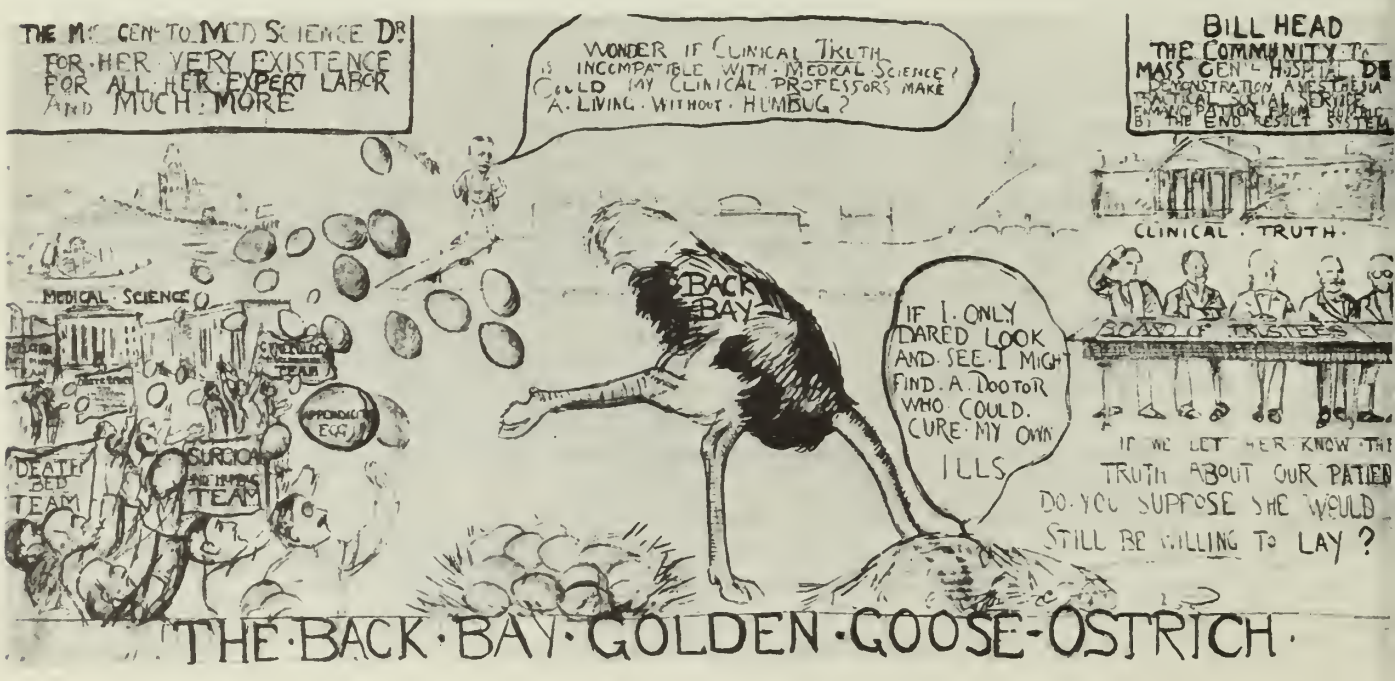
The most casual student of this problem realized that there was no basis for evaluating the result of patient care in our hospital system, because there were no records to evaluate. It would be like trying to judge the performance of a corporation that did not keep books. When a method of accrediting hospitals was formulated — setting up criteria for judging the quality of a hospital and its staff — the single most important element was a proper system of keeping records. This phase of the effort to improve medical care is far from over. In fact, many institutions have decided that at present there exists no satisfactory method for keeping adequate records, and some lively experiments by Weed and others are being carried out on a large scale to perfect a system that will enable someone to make an estimate of how our medical apparatus is performing.

Of the three property rights, the correction of the evils deriving from self-responsibility is the most dificult to achieve. It should be quite simple to evaluate a doctor's performance in areas such as surgery or medical cases with a proven diagnosis. Beyond this consideration lies the inscrutable makeup of man — half animal and half God — with the shaky and uncertain combination of reason and instinct that makes for continual instability. Here lies the basic cause of most illnesses and accounts for the fact that one of six hospital beds is occupied by a schizophrenic. How does one evaluate a doctor's performance in treating the mental component of illness that plays so great a role in patient and family? Anyone with measuring sticks please step forward.

We must continue to develop standards of care and criteria for evaluation, but always realizing that medicine is not a perfect science, and at best the measuring tools that we use must be subject to continuous reexamination and correction.

Government in Medicine

My thinking is not so fatuous as to conclude that these lines will slay the dragon of what doctors consider to be their property rights. This is a tough old creature and does not yield to such simple measures as verbal attack. A physician may, and often does, leave his training with idealism and high hopes for helping suffering



Conformity is the greatest hope for survival in a competitive atmosphere.

mankind in an atmosphere of mutual understanding and respect on the part of his professional colleagues. He soon discovers that the older members of the fraternity have developed practices and conventions that appear inconsistent with his principles. The realization dawns on him that conformity is the greatest hope for survival in a competitive atmosphere; so he makes a pragmatic adjustment to a system that he did not invent and may dislike thoroughly. After five years of practice the doctor has been brainwashed sufficiently so he has habits and routines that enable him to work efficiently within the medical community. His posture is that of a conservative, a member of the establishment, and as Hippocrates says, "Those things which one has been accustomed to for a long time, although worse than things which one is not accustomed to, usually give less disturbance."

The great majority of practicing physicians have been in practice over five years, and they may see serious flaws in their method of handling patients, but to change them would be much too upsetting for their taste. Their general attitude is, "Do anything after I am through, but please don't rock the boat now, Charley." It would be insincere on my part not to confess that were I in the middle of my career as a practicing surgeon and anyone made suggestion that we discard the "property rights" I have enumerated, I would perhaps question his sanity or motivation, and certainly would make every effort to forestall action. It is for this reason that I believe the radical adjustments and changes that are needed to bring about a truly comprehensive medical service in the United States can only be accomplished by federal legislation.

If there is any consistency in the record of American physicians it has been the opposition to any government control or interference in their area of property rights. A study of medical development the world over shows that this has been a universal attitude by the profession. The leitmotif of the argument is that government in medicine lowers the standards of care and interferes with the patient-doctor relationship to the detriment of the highest quality in service.

One need only cite the case of Sweden to demonstrate that this is not true; quite the contrary, Sweden has the best vital statistics in health of any nation in the world. When one mentions Sweden to a group of doctors, their immediate reaction is, "The country is socialist. You can't apply anything they do to the U. S. We are different."* There is no effort on my part to suggest that the U. S. should or can adopt any system from another country. What we should discuss without arousing passions, if that is possible, is that a participation of government in the planning and delivery of health services can have a beneficial effect on professional performance and end results.

The Swedish system makes good medical care a public service to which everyone is entitled. It is the responsibility of the political divisions — 24 counties — to provide the facilities needed in their area and to make available, through consultation, the services of a large center which is located in each of seven medical districts. The hospitals in Sweden are owned and run by the state or county governments, and financial support comes from government subsidy or payments from some form of health insurance. The result of this arrangement has been the avoidance of duplication in services which plagues the United States and places a heavy financial burden on our communities. I need not document this statement further than to refer to our four cities from Portland to Bangor each with its Protestant, Catholic, and Osteopathic hospitals.

Swedish medicine is far from a governmental organization where doctors are dictated to by elected or appointed officials. The profession has a great responsibility in maintaining high standards; this is achieved by a close and continuous working relationship between the bureaucracy and the physicians. All

* We should be quite clear about our definition of socialism. In the classical sense it is the ownership of the means of production by the state, and in this context Sweden is very much a capitalistic state, for 94% of the productive capacity in the country is privately owned. Sweden is really a Welfare State under a capitalistic system, whereas Russia is a Welfare State under a true socialism.

of the medical work in Swedish hospitals is done by full-time physicians, who have qualified through training and experience to assume their responsibilities with competence. In case there is a vacancy for the position of surgeon-in-chief of a county hospital, the opening is made known to the profession, and anyone who wishes can apply. The medical society will then select the three candidates whom it considers most suitable, and the county officers will choose the one of these three that they favor.

An exemplary performance of Swedish medicine has been in the treatment of cancer of the cervix. For years, all patients suffering from this disease were cared for in the Radiumhemmet in Stockholm, whether they lived 1,000 miles away or in the city. The results achieved at the Radiumhemmet have never been bettered or equaled by any other group in the world.

It may well be the time for the American medical profession to reexamine some of its fossilized clichés, particularly the one which holds that government in medicine is per se bad medicine. There is a happy medium between total subservience to bureaucracy and the rugged, individualistic principle of property rights. It is this area that we should explore, if for no other reason than the obvious preoccupation of Washington with a program for a comprehensive medical service.

Fantasy

Let us assume that practicing physicians agree to scrap their concept of property rights and substitute for them a working partnership with the government. The basis of this confederation would be to make available to all the people of this country an adequate system of medical care. This would not eliminate the institutions of "free choice" and fee-for-service if patients wanted to continue this arrangement, but the emphasis would be on the responsibility of the profession to furnish services to everyone, so that some professional person would be available to handle all problems pertaining to health in any area of the country, rural or municipal.

With increasing emphasis on group practice, contract medicine, and full-time heads of departments, the concept of salaries for physicians is being accepted. There is no evidence to my knowledge that by-passing fee-for-service and "free choice" of physician has lowered the quality of medical care. To the contrary, a physician on salary can devote his entire energy to carrying out the professional duties for which he has been trained, without the distractions and distortions that are introduced by continual preoccupation with monetary considerations.

In return for such a concession, the individual physician would be promised the following Bill of Rights:

> A physician is entitled to compensation that places him in the middle-income group, with the latitude for special skills, training, and performance that the range of "middle income" implies.
>
> A physician should earn enough to secure a comfortable living, with holidays, and hours of work that allow for recreation and continuing education.
>
> A physician should be able to provide his children with the education that they require and deserve.
>
> A physician should have guarantees for disability and retirement income.

In return for giving up the "property rights," which are incompatible with a National Health Service, doctors should insist on some such financial guarantee.

Prediction

In the many articles that are being written about the future of American medicine, there is little discussion about the issue of the physician's property rights. Yet this is essentially what the A.M.A. is championing so vigorously in advocating an insurance plan that is only an extension of the present system of Medicare and Medicaid, which are colossal failures. To expand them further would only invite disaster.

When one studies the development of total health services for a people, one discovers what might be termed universal issues. The doctors and governments always agree on the high purpose of adequate care for those who need it. Once having harmonized on this magnificent cause, their partnership for health explodes on the issue of how doctors are to be paid. Fee-for-service has been defended in every land as staunchly by the profession as the politicians have been vigorous in their effort to destroy it. In Australia, Canada, Italy, Britain, Germany, and you name the country, any preconceived property rights of the physicians have been unable to survive intact the pressures of a government that was determined to provide total health services for its citizens. I see no evidence of the type of leadership in the profession that will prevent us from duplication of these sordid and unnecessary conflicts.

It is said that those who do not benefit from history are forced to repeat it. We will hear the monotonous replay of name calling; references to Hippocrates and his oath; minority groups pointing to the doctor's greed; medical societies damning slippery politicians who are only trying to gain votes at the doctor's expense; and a panegyric to the glorious history of medicine — these will be repeated while the basic issues are disregarded. My crystal ball says that the United States will make all of the classical mistakes, only with this difference — we are a big country, and therefore our aberrations in conduct will be magnified proportionately.

This pessimism derives from the consideration that human nature has not changed since Machiavelli wrote, "There is nothing more difficult to carry out nor more dangerous to handle than to initiate a new order of things."

Dr. Lium is Special Projects Coordinator of the Tri-State Regional Medical Program.

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The Next Twenty-five Years

by David D. Rutstein '34

To have had the freedom to search for the truth, to be part of an institution that has devoted itself to freedom, has been a great privilege, but has not been easy in recent days. Several months ago, a group of left-wing students prevented a speaker from addressing a meeting of right-wing students who supported a continuation of the Vietnam War. The former were emotionally upset and righteously indignant as they equated a continuation of the war with the crime of murder. But righteous indignation has never been a justification for tyranny. Under the leadership of President Pusey, and through the action of Professor Archibald Cox, Harvard reacted in an appropriate manner and once again reaffirmed that any member or guest of the University, has the right to express his opinions and his beliefs without restraint, provided he does no bodily harm to and does not interfere with the rights and freedom of others.

The eternal quest for truth through freedom has been the hallmark of Harvard University since its beginning. The symbol of the open book with veritas emblazoned on it, first appeared in a Report of a meeting of the Overseers in the year 1643, although it was not included in the official seal until 1885. Indeed, the right of dissent, the right to express an opinion contrary to that of the established order was an accepted principle early in Harvard's history. As a result, Harvard became the cradle of dissent in North America.

Two centuries later, in 1869, President Charles W. Eliot epitomized the guiding principle of university freedom in his inaugural address when he said, "A University must be indigenous; it must be rich; but, above all, it must be free . . . the Corporation demands of all its teachers that they be grave, reverent, and high-minded; but it leaves them like their pupils, free."

There have been many occasions to refer to this guiding principle in Harvard's subsequent history. Immediately after World War I, nation-wide fear and insecurity threatened freedom at Harvard. President Lowell, during the term of an Attorney General whose middle name was Mitchell, defended Professor Zechariah Chafee, Jr., when he denounced the lack of fairness of the judge in the famous Abrams sedition case, and later Mr. Harold Laski, a lecturer at Harvard, when the latter spoke out in favor of the Boston police strikers.

The eternal quest for truth through freedom . . .

When we were searching for a way out of our severe economic depression, in 1936, I remember hearing President Conant in his Tercentenary Address take advantage of Harvard's freedom to express unpopular ideas when he stated, "the origin of the Constitution . . ., the functioning of the three branches of the Federal Government, and the forces of modern capitalism must be dissected as fearlessly as the geologist examines the origin of the rocks."

When the University was threatened with having funds withheld unless certain professors were dismissed, both Presidents Lowell and Conant made magnificent statements defending the freedom of expression and the search for the truth at Harvard in their Annual Reports of 1917 and 1948, respectively. The professors in question were Hugo Münsterburg during the strong anti-German feeling in World War I, and Harlow Shapley and John Ciardi during the McCarthy era. Who can forget the McCarthy era — the major threat to freedom during the last 25 years? Thanks to the inspiring leadership of Presidents Conant and Pusey, Harvard became a beacon that in no small measure helped to lead our country back to freedom.

ENOUGH of Harvard's history. It is pleasant to dwell on past successes, but it is more important to look forward to the world President Bok will face as he continues the Harvard tradition of maintaining freedom in the quest for truth.

The storm clouds of governmental interference in individual freedom are overhead; the showers have begun. All three branches of our national government have moved to suppress the freedom of the individual. President Nixon and Attorney General Mitchell have declared that the national administration has the right, without a warrant, court permission, or any other limitation, to pry into our private lives, using "taps" and "bugs" if they have any reason to believe that we may be a threat to the country. They have, of course, assured us that they will use proper restraints. The Supreme Court has recently confirmed the constitutionality of "bugging" an informer while he interrogates a suspect, and the use of that information as evidence in a court of law without further documentation. A committee of the Congress recently sub-

poenaed all of the background material used by a national broadeasting chain in preparing a documentary on the public relations aetivities of the Pentagon — a television program that aroused the haekles of our national administration.

If this trend continues, the freedom of the university will be threatened. Harvard has seen many similar governmental intrusions in the past. Our University can call upon its extensive clinical experience at the siek bed of society and, as it did in the McCarthy era, help guarantee the maintenance of a healthy demoeraey. There may be a long and diffieult struggle ahead, but, with the assistanee and good sense of the Ameriean people, I am eertain that the freedom of the individual in the United States will survive.

Harvard will also have to faee two new problems eoneerned with freedom, where the guidelines are less clear. The first is the drive by our youth for absolute autonomy and control, and the second, the preservation of the traditional role of the University as it provides leadership for a better society.

Young people are properly disturbed by the world that our generation has ereated for them — a world in whieh the beautiful treasures of our planet are being witlessly bulldozed away leaving the seabs of pollution to stare us all in the faee — a world in which we ask them to saerifiee their lives in a distant land for vague, undefined moral objectives, while here at home we begrudge the use of our resources to feed the destitute, educate the children, eare for the siek, and widen opportunities for the under-privileged. To quote Linus in the "Peanuts" eartoon — "I (we) love mankind, it's people I (we) can't stand."

In the light of this heritage, and with their almost eomplete lack of experienee in dealing with major problems, we really should not be surprised that the reaction of the young has been a convulsive one. We have seen violent, spasmodie, and purposeless movements, together with an almost eomplete laek of any

The storm clouds of governmental interference are overhead.

eonstruetive aetivity that might build for the future. Most of the words have been negative — tear down, burn, obstruet, and stop anything that is left over from the past, as if the aetual proeess of destruction were by itself automatieally ereative. Again the reactions are understandable. Youth has grown up in an era of great prosperity; and most of those whose status and background have favored their admission to a univerSity have been proteeted throughout their lives against having to overeome serious handieaps.

The sueeesses of their early destruetive aetivities and their laek of experienee in surmounting major tasks led to an arroganee, particularly in our universities, where, by their own admission, youth beeame the sole repository of knowledge and wisdom. The rule was — forget everything from the past and if you are smart enough, and if you can have your own way and don't have to bother with suehnonsense as elasses and examinations, you ean figure it out all by yourself, and it will be good for everybody. (Sometimes this is called independent study). Youth say little or nothing about ereating a new and better world through the long and diffieult road of researeh, planning, designing, working, testing, and evaluating. They suddenly know all the answers, but do not know and do not mueh eare what the questions are. I believe that we are now just beyond the peak of that reaetion.

IN practical terms, there has been almost a complete laek of understanding among many of the medieal students that the sinews of the body of aeeumulated knowledge are faets, the reproduetible observations around which we build the ideas, eoncepts, meehanisms, and theories that govern

the maintenance of health and the prevention and treatment of disease. Many matriculating medical students scorn memorization of facts maintaining it is beneath their dignity. To be sure, medical education has at times placed too great an emphasis on pure memory. As a medical student, I had to learn the origin and insertion of the more than 200 voluntary muscles of the human body. But even that didactic information, if combined with functional mechanics of the skeleton, is essential to the future orthopedic surgeon, and is the basis for the education of such paramedical personnel as physiotherapists.

I agree that memorization should be kept to a minimum, but I do not know how to learn or to teach the significant ideas of either the basic or applied medical sciences unless I know the special vocabulary for each of them, the meaning of the words that make up the sentences. I should like to propose a solution to this problem of rote memorization. A relatively painless method of teaching basic medical vocabulary could be developed at Harvard by using interactive programs on teaching machines to make a game of the dull process of memorizing terms, and save lecture time in the process.

Some of the students to whom I teach clinical preventive medicine on the hospital wards have suddenly become aware of the self-induced inadequacies of their basic knowledge. They are working extremely hard to repair the gaps in the first two years of their medical education and are grateful for any teaching effort that relates the details of underlying structure or mechanism to the clinical picture of a disease. Taking advantage of feedback from such students may help in the reorientation of the matriculating medical student of the future.

and rid them of the many defects that have been pinpointed by the students. We must always seek student opinion on matters that affect them and their advice in those situations in which they are competent. But, it is up to the faculty to supply the leadership and direction; and I fear that there have been too many times when we have failed to meet this responsibility.

If they are to survive, universities must continue to perform their traditional dual roles.

One of the ways to meet the new challenge of youth is to make students aware of the process by which knowledge is accumulated. In so doing, I believe it will be worthwhile, if the implications of the word "discipline" as applied to a field of knowledge, were carefully reexamined by faculty and students working together. Indeed, as a model for the future, an historical review of the evolution of the different disciplines in our universities would be most revealing, especially to those students who believe that knowledge can be accumulated by meditation alone. Paralleling this process, we must review our teaching programs

The student demand that the university play a greater role in social change leads to perhaps the greatest challenge now being faced by the university. How can the university influence the structure of our society in a "relevant" way and yet maintain the freedom and the independence necessary for its objective, dispassionate, and untrammeled search for the truth?

As its primary responsibility, the university must continue to perform its traditional dual role, to teach and to increase knowledge; to teach by increasing the confidence of the student, bringing him to the threshold of his capabilities, and opening his eyes to challenging possibilities so that he will be motivated to learn for himself; to increase knowledge by surrounding scholars with an academic environment sheltered enough so that the quest for the truth will not be perverted by the pressures of an immediate emergency.

To these traditional roles must be added the new university responsibility of supplying wise guidance to our evolving society. Such guidance would be in the form of deriving ideas from man's accumulated experience, asking the pertinent questions, conducting the experimental testing of proposed solutions, devising practical implementation of theo-

In the future, research may be less elegant, but it will be more practical.

retical concepts, and objectively evaluating the results. All of these are essential to social progress; all demand the dispassionate thinking of the university scholar. Such steps can be performed successfully without bringing the university and its faculty to the barricades where the immediate conflicts are incompatible with objective scholarly activity.

FOR a perspective on the future role of the university, let us turn to history for guidance. During the past thousand years, the university, like the church, has been seriously challenged at two separate times; during the Renaissance and today. During the Renaissance, the church was faced with the Reformation, and scholars in the universities became unwilling to blindly accept the voice of authority. In medicine the revolt was against the authoritarian teachings of Aristotle concerning the structure and functions of the body. In the 16th century, Vesalius, the father of modern anatomy, turned away from classical teachings and, at the risk of his life, dissected the bodies of executed criminals to see how they were really put together.

Those elements of both institutions that were able to adapt to the changing environment of the Renaissance survived; others were less fortunate. The monks, who sat so quietly in their isolated cloister cells illuminating their beautiful manuscripts, completely removed from the changing social scene, failed to notice the discovery of the printing press that was eventually to do away with their art. The handwritten word would never again be so beautiful, but through printing, knowledge and ideas have since been widely disseminated and public education has become a reality in many parts of the world.

Today, both the church and the university are being challenged on the issue of their relevance to society. Again, the voice of authority is being questioned; this time on the nature of our social environment. As a result, it is no longer possible to justify conclusions based solely on authoritarian, undocumented statements of pundits in the fields of individual and social behavior. Just as Vesalius did with the human body, so must we, at whatever risk, reexamine human behavior and social structure. Using our new quantitative methods, we must learn how such things are really put together and the reasons why they do or do not work. This will not be an instantaneous process. Even today, over 400 years since the death of Vesalius, the majority of medical decisions are educated guesses. But, we have a growing body of documented knowledge that year-by-year allows us to effectively save lives and to prevent and treat more and more human disease.

We now must begin in more specific ways to attack mental disease and the illnesses of our society. We have been handicapped because in both situations there are so many factors changing at once, so many variables, that with our unaided brains we have been unable to follow them simultaneously or to determine how they interact.

Thanks to the computer we can now perform rapid, simultaneous analyses of many variables. We are entering an era when we can unravel the complexities of healthy, or physically or mentally sick human beings, and the social system. We therefore have a tremendous responsibility. It remains for university scholars to revolutionize the design of experiments to take advantage of this new and powerful instrument in the study of entire individuals and societies.

Let me illustrate this last point with the example of the basic medical scientist. Our basic medical scientists have been conducting their penetrating research in systems far simpler than those of the intact animal or the human patient. As a result, although their findings are dramatic and revolutionary, they have little immediate applicability to the prevention and treatment of disease. With our new technology, however, they can now do basic research on more complicated systems, such as that of the entire human patient.

Our ivory-towered, white coated scientists have a choice. They may choose to imitate the monks of the past, ignoring the social changes around them by continuing to perform their elegant experiments in simplified systems. If they make that choice, the computer will do to most of them what the printing press did to the monks. Or, they may choose to expand their horizons and direct their basic research toward the study of human beings, as the newer creative social scientists study entire social systems. The conclusions of their studies will apply directly to the improvement of the human condition and the social structure. Research may not be as elegant in the future, but it will still be basic and should have more immediate, practical application to man and to society.

The university of the future can no longer be isolated, but neither can it engage in flag waving revolutionary activities. It must strike a delicate balance among its three roles. The university, sitting at the heart of progress, must teach students, accumulate new knowledge, and provide for the basic elements of constructive social change.

Dr. Rutstein is Ridley Watts Professor of Preventive Medicine at HMS. The above is based on a talk given at the 17th Annual Twenty-five Year Recognition Ceremony at Harvard University in May, 1971.

Revival of the Roots:
Full Circle

by Gerald Mungerson
General Director, BHW

THE Boston Hospital for Women, relatively unknown compared to its parents, the Boston Lying-in and Free Hospital for Women, continues to bear the heritage of extending itself into the community. The roots of community service stem from McLean and Washington Streets where the Lying-in and Free were founded in 1832 and 1875, respectively. These roots branched out with the creation of outpatient departments in 1881 and 1879.

For the Free Hospital, the outpatient department was a traditional one, but for the Lying-in, it meant that " . . . Medical attendance at their homes is furnished during confinement to all women residing within the city proper who are unable to pay for such services." Hence the BHW's first extra-hospital patient care program was born. It was not until 1911 that a traditional outpatient service was established at the Lying-in. The motivation of both hospitals, however, was to provide care for patients prior to hospitalization — a goal that time has served to strengthen.

Rapid growth was not a characteristic of the early days of outpatient clinics remote from the hospital. Although it was operating five clinics, the hospital was discouraged by their lack of growth which was attributed to the belief that the public did not want or need care as long as it was not suffering.

During the early and mid-1920's, the Lying-in began to open satellite clinics, and by 1931, was operating 13 community clinics accounting for well over 20,000 patient visits yearly. During this same period, however, the number of home deliveries fell as patients moved into the hospital setting. After 1931, the pressures of manpower, essentially caused by the War, closed the clinics; the last one shut its doors in 1947, a relatively short 24 years ago.

The Free Hospital for Women established an outpatient department in 1879 at 16 Springfield Street where it remained until 1908, although in 1896, the main hospital had moved to its present location on Pond Avenue. The reasons for bringing the OPD to the hospital are worth noting.

> It can readily been seen . . . that a large and important department of the hospital situated at so inconvenient a distance from the main building, improperly housed, holding valuable records peculiarly

liable to various kinds of accidents, and in general inadequately supervised must necessarily have been a source of anxiety. . . . A considerable sum of money has been raised to provide free transportation of patients in bad weather from the electric car line to the hospital.

Both parents of the BHW had their roots in the South End, roots that, as we shall see, have been revived by a compound containing a dose of federal money, a measure of support from state and local governments, and a growing commitment to community care.

Satellite clinics for BHW lay dormant for 20 years and it was not until 1967 that, with the help of the State Department of Public Health and Harvard Medical School, the Boston Hospital for Women and Children's Hospital Medical Center assumed sponsorship of the Bromley Health Well Child Clinic in the housing project of the same name. This clinic, established and operated by the Harvard School of Public Health under Dr. Martha Eliot's guidance, opened its doors in April 1967 to provide maternal and infant care, as well as comprehensive child care, to residents of four-and-one-half census tracts in northern Jamaica Plain. Appropriately, with Dr. Eliot present, the center was rededicated in her honor — the Martha M. Eliot Family Health Center.

This represented the re-entry of the BHW into the community, although by no means should it imply that the hospital had not been providing care to the community. Indeed, during the intervening 20 years, the hospital had cared for more than 75,000 residents of Boston, all of whom were unable to pay the full cost of their care.

The Martha M. Eliot Center was the first step back. Since then, the hospital, through its medical staff, has expanded even further. Currently it is providing obstetrical and gynecological care to a mostly Puerto Rican population through its affiliation with the South End Community Health Center. While this

Center does not serve a proscribed geographic area, as does the Martha Eliot, the number of patients cared for by our staff physicians is approximately the same.

More recently developed is the East Mystic Clinic in Somerville. This Clinic, located in a housing project, serves approximately 500 families, well below the 10,000 plus at Martha Eliot, but equally in need of maternal care.

In a less direct way, the BHW is involved with the community via its participation in the Mission Hill branch of the Harvard Community Health Plan. Similar in nature is our budding involvement with the Model Cities Family Life Center in Area 1. In the process of unfolding is the BHW's participation in Health, Inc., a plan designed to bring comprehensive health care to populations without access to such care.

While much of this sounds like, "what have we done for you lately?" the more important issue is, of course, where does the BHW go from here? Our commitment is firmly stated in our own Mission Report.

> *Community Responsibility:* The Hospital will offer health care to women and newborn of Metropolitan Boston, as well as those referred from anywhere with special problems. Its activities will not be limited by the physical boundaries of the Hospital but shall extend into the community and home. The Hospital will coordinate its planning, insofar as possible, with its sister hospitals in the AHC, with the Children's Hospital Medical Center, with the other Harvard Affiliated Hospitals, with Harvard Medical School, with the other university medical centers in the region and with local, state and regional planning agencies. It shall at all times maintain its identity, serving as a national or even global example of excellence in its field.

This is a large order. Perhaps it will never be achieved in the literal sense, but it reaffirms our obligation to stay where we are and to provide care where it is most needed.

Our current pattern of organization is inadequate to meet these goals, as is haphazard underfinancing symptomatic of the health system in general. Physicians must be brought closer to the hospital so that they and their assistants can serve more patients. The BHW must be closer, in a physical and organizational sense, to those who can make comprehensive care a reality. The BHW, through affiliation and planning, must be in a posture to care for the "total woman."

Thus, we have come Full Circle. Founded in the South End 138 years ago, the Boston Hospital for Women is still there, and is pledged to remain so.

EDITORIALS

A Garland for Joe

Readers of the *Harvard Medical Alumni Bulletin* do not need to be reminded of the virtues of their Editor Emeritus, Dr. Joseph Garland. We, the ἐπίγονοι happily take the occasion once again to quote some Garlandiana, which cannot fail to delight the connoisseur of same, nor find happy new readers (we almost said readership). We excerpt herewith an editorial entitled "Wordmanship, No Less" in which Dr. G. exposed his strictures, unavailingly perhaps, about "relationship" as opposed to "relation."

"The case in favor of relation and against relationship except in a restricted sense having thus been clearly presented and incontrovertibly proved, it may be pertinent to recall a luncheon-table conversation about the sinking of the *Titanic* that took place in the Harvard Club of Boston, on the anniversary of that melancholy event. "I had relations on the *Titanic*," one discussant modestly admitted. "With whom?" was the spontaneous interrogation of his fellow Harvardmen, striving for their own scholarly version of one-upmanship."

Many readers will recall the pleasures of horsechestnutmanship, recounted by Dr. Garland as follows:

"I remember well one such addict to horsechestnutmanship (horsechestnuts carried in the pocket to ward off rheumatism) who averred that he had been absolutely free from rheumatism.

"And had you been greatly troubled before that," I asked.

"That's the most remarkable thing of all," he replied, "It's retroactive."

And perhaps the same may be said of the editor's joys and rewards."

In a serious vein, touching upon his role as editor of the *New England Journal of Medicine*, Dr. Garland once summed up the essential task he discharged so well:

"The selection and often the solicitation of this content is the first function of the editor and his board, but particularly, of the board, for few physicians today, however experienced, would care to set themselves up as the sole directors of any journal's program. The second editorial function is to insist on clarity in diction and simplification of the text, purging it of unnecessary words in preference to abbreviating necessary ones."

This editor had scarcely finished copying that classic paragraph when, with a twang of her lyre, the Muse alighted and dictated the following verses, which, with the footnotes she provided, establishes her as the Muse not only of Verse, but of Scholarship:

A Garland (1) for Joe (2)

Some say we do not need well-worded thought
In journalism of today, but ought
To try for speedy printing of our stuff,
Contented, though it's pretty rough.
Such, all known, is not Joe Garland's way:
Master of blue pencil he,
Of ease and grace and verity,
Strong in the faith that Truth survives the day.

Stay with us, Joe, and teach us how to write
Such prose as makes Alumni take delight!
Show us how to be "relevant" to the young,
And yet not leave the old unsung;
Make the tired doctor want to read,
Tempt the well-read to read still more!
Celebrate with us fourscore
Years of Words transcending common Deed!

You need no added stars, now for your crown:
You've given the World what once-served Boston-town.
But we late-comers still have need of you,
Your wisdom and your humor, too.
A Garland we need, of hearts'-ease and good will!

Let not the laurels of success,
Be harvested in bitterness:
But fellowship's, wordmanship's Garland, blooming still!

REFERENCES

1. gar′ land (gär′ l̄and), n. (OF. garlande.) 1. A wreath made of branches, flowers, leaves, etc.; chaplet. 2. A book of extracts; an anthology; esp., a chapbook or broadside containing one or more ballads or songs (Webster). The Muse implies that the Bulletin itself may be the garland. (Ed.)).
2. (The mode of address indicates the Muse's familiarity with Dr. Garland (Ed.).).

The Demanding Patient:

Another Input for Dr. Rutstein's Computer

"To cure — sometimes; to comfort — always." Implicit in this classic statement of the duties of the physician is a concept which has become increasingly impractical in medicine today: the concept of a satisfied customer as the product of the physician's best efforts. Today's overworked practitioner may have little time to instruct his patient in the nature of his illness and the goals of treatment. He is certainly unlikely to feel any need to sell him on it. To the extent that this is true, there is bound to be customer dissatisfaction, which can result in phone calls, additional office visits, and calls upon other practitioners, including "quacks" alas — all of which might have been obviated at the first visit.

Perhaps we must be resigned to all this. The days may be gone, if they ever existed, when a physician could pride himself on his care of a demanding patient. And yet, Dr. Lium's article reminds us of the jealously guarded concept of the free choice of a physician which is held as though there were still a free market in which the dissatisfied patient could shop around.

Let us for a moment suppose that there is such a market, that physicians have hung out their shingles and are hoping for a call from the dissatisfied patient of Dr. X. That call, today, comes not from a dissatisfied patient, but from a consumer group or an organized community. It is now the group, not the individual, that complains about a patient coming in with a bunion and being treated for constipation, or whatever the complaint might be.

Such calls will surely come to us with increasing frequency, *whether or not* we want them. We hope that medicine, allied to government or not, will pick up the phone and respond. It is not only within the tradition of medicine to do so, still more, it is within the tradition of the doctor/patient relationship. Let Dr. Rutstein put the demanding patient (or the community's "demands") into his sociological computer. Let doctors and patients go to the government, as Dr. Lium suggests, for the needs of their relationship. Let there be free choice and failing this, let the demanding calls increase, and the quacks flourish! (In future issues, the *Bulletin* will publish articles about communities and hopefully, an article about quacks).

Along the Perimeter

Program to Focus on Human Health Needs

In an unprecedented collaborative effort, Harvard and Massachusetts Institute of Technology have launched an innovative educational program.

The complementary strengths of both institutions are directed to developing new kinds of physicians and other health scientists, to applying modern science and technology to health problems, and to integrating more effectively the natural, social, and behavioral sciences, engineering, and management with medical education and health care.

The Harvard-MIT joint Program in Health Sciences and Technology, which focuses science and technology on human health needs, has three parts:

> curricula to qualify students to enter the clinical years of medical or dental school;
>
> curricula at the interfaces of human biology and engineering; the physical sciences, and mathematics; and
>
> curricula in human biology to qualify the student to pursue graduate study in the life sciences.

Providing the framework for scientists and engineers to work on clinical problems and for physicians to work with scientists and engineers, the courses in the program are designed to achieve progressive penetration of the physical sciences and engineering into biology and medicine, and to develop an informed social and behavioral analysis of human goals and cost, and the human meaning of health activities.

Because of the growing awareness among physicians of the need for greater intellectual support from the physical sciences and engineering, one part of the program is directed at developing such physicians. Examples include the cardiologist with a knowledge of electrical engineering, a dentist with an understanding of biomaterial science, or a physician-administrator grounded in economic theory and public policy.

The second part of the program seeks to develop biomedical engineers who would apply their skill and knowledge to biological systems and to solving health problems. Examples include biomedical engineers concerned with control systems and life support mechanisms, biomaterials scientists involved in the development of artificial organs and prosthetic devices, and fluid-dynamic experts seeking a deeper understanding of such biological phenomena as heart function and blood flow.

Still under development, the third part of the joint program will edu-

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cate biochemists, biophysicists, and biomathematicians oriented toward human biology.

Twenty-five students, all selected from Harvard, Radcliffe, and MIT, are enrolled in the program. They are the equivalent of the first year classes entering many newly established medical schools in the U.S., and are in addition to the 140 students in the HMS Class of 1975. In future years, students will be encouraged to enter the joint program as soon as they are qualified, possibly at the end of the third year of college, thus shortening the college-medical school experience from the usual eight years to seven or less.

Director of the joint Program in Health Sciences and Technology is Irving M. London, M.D., formerly professor and chairman of the department of medicine at Albert Einstein College of Medicine. General guidance is provided by an administrative committee including: Dean Robert H. Ebert; Walter A. Rosenblith, MIT Provost; Harvey Brooks, Dean of Harvard's Division of Engineering and Applied Physics; William F. Pounds, Dean of MIT's Sloan School of Management; and Henry C. Meadow, Associate Dean of Harvard Medical School.

Culver Chairs Alumni Council Meeting; Langone Elected First Associate Member

Faced with a hefty agenda, the Council of the Harvard Medical Alumni Association met on October 9 in the Minot Room of the Countway Library. All members were present except John W. Kirklin '42 and John A. Schilling '41, both of whom had previous commitments.

Perry J. Culver '41, new director of alumni relations, opened the meeting with a discussion of the nominating committees for candidates for officers and councilors of the Harvard Medical Alumni Association.

The Committee of Three nominates the officers; the Committee of Five chooses the candidates for the council.

In the past, members of the nominating committees have been from older classes and younger members of the association have seldom participated in the selection of candidates for office. The Council was unanimous in its agreement that the members for both committees should span a broad age range, and that the nominees chosen by them should represent diverse geographical areas and age groups. The inclusion of younger members on the Council is guaranteed this year because of the recent passage of By-Law III.

Turning its attention to a re-examination of qualifications for associate membership in the Harvard Medical Alumni Association, the Council, after lengthy discussion, proposed the following definition for paragraph "b" of Section 4 of the Constitution (see page 25, May-June *Bulletin*). All persons who have held a clinical, teaching, or research appointment at a Harvard teaching hospital for one year or longer shall be considered associate members of the Harvard Medical Alumni Association. Associate members shall have all privileges of full members save the right to vote, which, by University governance, is granted only to graduates of the various Harvard faculties.

In conjunction with associate membership, the council reconsidered paragraph "c" of the newly-amended Section 4. Paragraph "c" states that associate members shall include anyone the Alumni Council deems worthy of such distinction by virtue of service to the School. The name of John Langone was presented to the Council for consideration in this category and was approved. Mr. Langone, a science writer for the *Boston Herald*, has taken two courses — gross anatomy and history of medicine — and has done much to present the story of Harvard medicine to the reading public of Boston.

Dr. Culver then presented to the Council a chart outlining the proposed functions of the Alumni and Alumni Bulletin offices.

One of the important priorities in the area of Alumni Records is to develop a program for data storage and retrieval. This is especially important in light of the associate member amendment. It will also be useful for the updated, accurate Alumni Directory to be published in 1972.

Fund raising has been of the traditional functions of the Alumni Office. A proposal to establish a Harvard Medical Alumni Fund Council, modeled on the Harvard College Council, was presented. Mr. Joseph C. Donnelly, Jr., director of development at HMS, briefly described how such a council might work. Its function would be to stimulate alumni and keep them informed of the fund raising activities of the Association. Members of the Fund Council would maintain close contact with the constituency and volunteers would be used extensively. Hopefully, the end result of such an endeavor would be greatly increased involvement on the part of the alumni and a significant increase in unrestricted financial support to Harvard Medical School.

Alumni involvement is an area badly in need of overhaul at HMS, and it was proposed that regional organization and activities be given high priority this year. Such regionalization would include annual meetings throughout the country in the yet-to-be-defined geographic regions. The dean, administrators, faculty, and students would attend these meetings to keep alumni informed on current trends at the Quadrangle. Alumni opinion on such items as long-range development and curriculum planning would be solicited. Regionalization would also include alumni involvement with the Medical School Admission Committee — college visits, counselling, and interviewing for admission. This year, alumni will be responsible, in a much more integrated way, for all applicant interviewing west of Pittsburgh and south of Washington. Re-

Continued on next page

gional interviewing will be modeled on the teehnique used at HMS and will be eonducted by groups of alumni, working in eonjunetion with an admission eommittee member.

Obviously, the best way to sustain interest in HMS is to keep alumni informed. Effieient regionalization is only one method of accomplishing this. Effeetive eommunieation through the offieial publieation of the School is another. The Counеil was in unanimous agreement that the *Alumni Bulletin* should be expanded to inelude more news of the departments of the School and more articles on the broader issues of health. There was a proposal before the Counеil to eonsider an ineorporation of the *Harvard Medical Alumni Bulletin, School of Public Health Bulletin,* and *School of Dental Medicine Bulletin,* but this was rejeeted, as was a proposal to inerease the number of HMAB's from six to eleven issues per year.

The remainder of the meeting was devoted to new business. The winter Counеil meeting will be held on January 21 and 22. Alumni Day is scheduled for June 2, followed by Class Day on June 3.

Following adjournment, the Counеilors and their wives lunched at Carey Cage and attended the Harvard-Columbia football game.

Miss Murphy Meets Her Scholars

Miss Murphy chats with Miss Casey and Mr. Kelleher

The first two reeipients of the Dorothy A. Murphy Seholarship are Rosemary D. Casey of Philadelphia, Pennsylvania, and Mr. Stephen P. Kelleher of Cambridge, Massachusetts. Both entered the first year elass of the Harvard Medieal Sehool in September, 1971.

Rosemary Casey was a student at Villa Maria Aeademy in Malvern, Pennsylvania. Her eollege years were spent at Immaculata College, also in Pennsylvania. Throughout her eollege matrieulation, Miss Casey demonstrated interest in people and medieine by working in many positions that brought her eloser to her ehosen areer. She held jobs at Graduate Hospital, was a teaehing assistant in Harlem for one month, and was a researeh assistant in the department of physiology at the Medieal College of Pennsylvania. Miss Casey was a member of the Biology Club on the Immaeulata College eampus, and was a student affiliate of the Ameriean Chemieal Soeiety.

Stephen Kelleher attended Matignon High Sehool in Cambridge, Mass., and Boston College in Newton. A biology major, he was a member of the Mendel Biology Club and in his senior year, served the club as its president. Mr. Kelleher was also a member of the National Honor Society, and was its president on the BC eampus during his senior year. Mr. Kelleher's interest in medieine developed early in his edueational areer, and he worked at Mt. Auburn Hospital as an orderly to further aequaint himself with his areer ehoiee. At BC he worked with faeulty members in the biology department doing researeh.

The Dorothy A. Murphy Scholarship Fund to date has reeeived $103,074 from 1,140 donors. The letter of solieitation was sent by the Committee for the Friends of Dorothy Murphy to only those classes who had known Dottie as students of the Medieal Sehool while she was in the Dean's Office. There are a number of people who entered Medieal Sehool after 1957 when Dottie beeame the assoeiate direetor of the Alumni Assoeiation who have expressed a desire to make a eontribution in her honor. Therefore, the books have not been elosed for the Dorothy A. Murphy Scholarship Fund and anyone who wishes may send a eheck with a note to the Alumni Offiee. Checks should be made payable to Harvard University.

Curran to Serve on HEW Commission

William J. Curran, J.D., Franeis Glessner Lee Professor of Legal Medieine, has been named to the Commission of Medical Malpraetiee, reeently established by Seeretary of Health, Edueation and Welfare, Elliot L. Riehardson.

The Commission will direet its attention to the basie eauses behind the increasing number of malpraetiee elaims and the resulting effeet on the general publie, the health eare system, the insuranee industry, and the legal system.

Professor Curran, who is also a leeturer on legal medieine at Harvard Law School, is the only member to represent both a law sehool and a medieal sehool faculty.

Innovative Program Examines Human Rights and Medical Ethics

A three-year grant of $150,000 has been awarded Harvard Medical School by the Joseph P. Kennedy, Jr. Foundation for a Program in Medical Ethics that will involve the Faculties of Medicine, Public Health, Divinity, and Arts and Sciences. The Kennedy Foundation, headed by Senator Edward M. Kennedy and a group of Trustees, view this program as an opportunity to support studies in the area of human rights and medical ethics that will afford professional people greater chance for training in these fields.

William J. Curran, J.D., Frances Glessner Lee Professor of Legal Medicine, Arthur J. Dyck, Ph.D., Mary B. Saltonstall Professor of Population Ethics, and Stanley J. Reiser, M.D., Ph.D., Instructor in the History of Medicine, will be the joint directors of the program. The overall administration of the grant comes under the jurisdiction of the Medical School, but the assistance of the other schools of Harvard will be sought.

This study is being undertaken at a time when a reappraisal of the moral basis for the medical acts of society and physicians is occurring on a wide variety of issues. To further understand these phenomena, the contemporary ramifications and historical evolution of ideas, events, and traditions will be examined. Other pertinent issues to be studied include: ethical considerations relating to clinical work with special patient groups including the mentally retarded and the aged; the effects of medical advances in genetics, fetal development, and biomedical machines on social and professional values; and the moral problems of withholding services by physicians in strikes and wars.

The courses, open to all students at Harvard University, will be developed around these central issues. HMS will offer a seminar, "The Physician in Society," which will be an introduction to the fields of medical history, medical ethics, and medico-legal relations. The School of Public Health will offer an advanced lecture course that will investigate the ethical and legal issues of particular significance to the health rights of individuals, including children, minority groups, experimental subjects, and the poor.

A portion of the grant will fund four fellowships offered to two predoctoral students and two postdoctoral students who, in the estimation of the program's directors, "show outstanding promise to develop careers in medical ethics, or who give evidence of being prepared to contribute important research to the field."

Letters

Principle of Academic Freedom?

To the Editor:

For some time after receiving your July-August issue, with its record of the Class Day program, I refrained from offering any comments on the irritating and irrational political views which were so freely aired on that occasion. I recognize how futile it is for one obscure and forgotten alumnus to influence the policies of a great establishment like HMS, which obviously are being shaped, on the one hand, by the brash, arrogant and self-assumed omniscience of certain vociferous students and, on the other hand, by the inexplicable willingness of several administrative leaders to surrender the authoritarian roles with which they are properly endowed by reason of tradition plus their greater maturity and experience.

Nevertheless, I am now submitting the following comments, not because I think them worthy of publication but because I am convinced that, if the principle of "academic freedom" be a worthy one, my views are as valid as any which were voiced on Class Day and which later appeared in print.

1. In chiding those alumni who have decided to discontinue making financial contributions to the School, Kim Masters '72 asserted, "To absent oneself from the institution because one's views are not accepted is really destructive to the fundamental goals to which we are all committed."

Would Mr. Masters concede that his generalization is equally applicable to the ten members of the Class of '71 who refused "to allow the military to use us for its admittedly violent and political ends?" Would he concede that it is *even more* applicable to the latter, since financial contributions are obviously voluntary, whereas military service is an obligation of citizenship, duly defined and approved by a democratic government?

2. Dr. McDermott '42, after observing that students' choices of elective courses were often erratic and unproductive, reported, "An effort is in progress to require a more organized and disciplined intellectual approach in the Elective Period. Areas of concentration . . . are planned with certain basic sciences and disciplinary approaches required."

Just prior to Dr. McDermott's statement, David M. Bear '71 had warned, "I should like to caution strongly . . . against premature required actions, wherever originated, to compel student submersion in . . . prescribed basic sciences. However evasively conceived . . . these moves will be stoutly opposed."

When the day comes — as inevitably it must — to decide be-

tween these diametrically opposed plans, the whole future of HMS will be determined by that decision.

3. The remarks of David Spiegel '71 demonstrated the same intemperance and disregard for truth he exhibited last year. For examples:

A. He implied that the U.S. is responsible not only for perpetuating the war in Vietnam but even for initiating it. Thus he totally ignores the historic facts that this conflict was well underway before the first American became involved and that it will continue with unabated ferocity after the last American is withdrawn.

B. He implied that the U.S. alone has been responsible for "over 100,000 deaths and a million casualties" during the last four years, again ignoring the fact that the Vietnamese people themselves have both caused and borne the great majority of the casualties.

C. He stated that "for every suture we tied and every . . . course of drug therapy we administered, our government killed thousands of people." If this be true one must conclude either that the present HMS curriculum is sadly lacking in opportunities for even elementary clinical experience or that the speaker is totally uninformed.

D. He implied that withdrawal of U.S. forces from Vietnam will automatically bring an end to the bloodshed there. He ignores the fact that South Vietnam is fighting for its very existence against the ruthless Communist forces of the world's most brutal dictator, Mao Tse-tung, whose purges and liquidations have already led to the deaths of some 35,000,000 of his own countrymen. Under his direction the North Vietnamese under Ho Chi Minh set out to subjugate the nation of South Vietnam. They invaded Laos and Cambodia to initiate vicious guerrilla warfare against South Vietnam, and nothing but military defeat will deter them until all of Indochina is subjugated by Communistic force. Withdrawal of U.S. military assistance greatly enhances the likelihood of a Communist victory, which will be followed by bloodshed more appalling and widespread than anything thus far seen in the war. Although Dr. Spiegel maintains that "any man's killing stains (his) hands," he apparently is unmoved by the prospect of wholesale slaughter in South Vietnam.

E. Concluding his impassioned appeal "to be willing to risk losses to bring what we do in line with that we believe," he made an incredible request: "Let us build a world in which no man's health and freedom is (sic) bought with another man's blood and suffering." This is true humanitarianism?

ALDEN W. SQUIRES '32

The above letter was forwarded to Dr. Spiegel, who offers the following reply:

In accusing me of "disregard for truth," you challenge me in a way which connotes disrespect as well as disagreement. A year ago in this journal you made some rather offensive remarks about me. At least this time you stated some specific points at issue. I have tried to provide factual information where you requested it, and I have attempted the more difficult task of rebutting the implications of some of your other points.

A. Nowhere did I state or imply that the US initiated the war in Vietnam. The tragedy of that war is heightened by the fact that we are repeating the mistakes of a previous colonial power, France. We are, however, responsible for massive destruction, regardless of what fighting might have occurred without us. If we really disengaged, which would mean ending the escalating air war and cutting off our massive military aid, the war would end immediately.

B. The Vietnamese people have indeed borne a large majority of the casualties. But if you look at the official casualty figures, they show an enormous number of North Vietnamese and Vietcong deaths in proportion to US and South Vietnamese deaths. In view of the fact that the US has done the majority of the battlefield fighting prior to the last year, it stands to reason that we have inflicted a large majority of the casualties. In the air war, an entirely American venture, we have dropped more bombs in Vietnam than in all of Europe in World War II, more in tonnage than many Hiroshimas. In addition, we have repeatedly violated the Geneva accords by bombing hospitals and schools; establishing "free fire zones," in which we kill anything in a geographic area; and by relocating one-third the population of South Vietnam. But more important, suppose we had only caused ten deaths, or one? We have no right to be there — even one death is too many.

C. An official US government survey, published in the *Boston Globe* of July 11, 1971, lists Vietnamese civilian casualties through Feb. 1, 1971, at 1,000,000 and Communist casualties at 715,000. Who is totally misinformed?

D. This section contains several misconceptions:

1. I don't know where the fantastic figure of 35,000,000 killed in China came from, but if our country were so interested in preventing purges, then perhaps we would have opposed, rather than aided, the massacre of one million Communists and Communist "sympathizers" in Indonesia in 1966, and perhaps we would try to stop the slaughter of Bengalis in East Pakistan today.

2. You stated that "Ho Chi Minh set out to subjugate the nation of South Vietnam." President Eisenhower stated that he suspended free elections in Vietnam in 1956 because Ho Chi Minh would have been overwhelmingly elected. Just a month ago, the Thieu regime, which we support, arranged an uncontested election. Who is subjugating whom?

3. Once again we hear the bloodbath theory. We have killed more than a million people. When will we stop killing people in the name of saving lives?

E. What do you want — good grammar or good taste?

DAVID SPIEGEL '71

book REVIEWS

Fundamenta Medicinae by Fricdrick Hoffman, translated and introduced by Lester S. King '32. 142 pages. New York: American Elsevier Publishing Company, Inc., 1971. $10.25.

Mainstreams of Medicine: Essays on the Social and Intellectual Context of Medical Practice, edited by Lester S. King '32. 186 pages. Austin: The University of Texas Press, 1971. $6.50.

Lester S. King '32, Senior Editor of the *Journal of the American Medical Association,* is one of the most productive and lucid writers in the field of medical history today. His earlier volumes are: *The Medical World of the Eighteenth Century,* 1958; *The Growth of Medical Thought,* 1963; and *The Road to Medical Enlightenment: 1650-1695,* 1970.

The *Fundamenta Medicinae* of Friedrick Hoffman has been translated and introduced by King as a part of the History of Science Library: Primary Sources series. The 1695 classic by Hoffman describes the conceptual conflict of 17th century medicine when the new discoveries in anatomy, physiology, chemistry and physics undermined the Galenic teachings that had held the stage for 14 centuries. King's translation is the first available, and his introduction is a masterful piece of historical writing that puts the work into perspective. One should also read Chapter V of *The Road to Medical Enlightenment, 1650-1695* for more information about the importance of this work. The translation of this volume is a major contribution to the history of medicine.

The Mainstreams of Medicine, edited by King, is a fine example of making the history of medicine relevant to the issues of today. The essays concern the social and intellectual context of medical practice, and provide a view of those areas in which the practice of medicine affects and is affected by the society it serves.

Presented at a 1969 symposium sponsored by the University of Texas Medical School at San Antonio, the essays include: Introduction: Medical Education in Mainstream by David A. Kronick; Great Medical Practitioners: A Historical Survey by Chauncey D. Leake; Medicine as a Function of Society, and The Disease of Civilization: Achievements and Illusions by Rene Dubos; The Emergence of the Hospital as a Social Institution by John Knowles; The Coming Revolutions in Medicine: A New Plan for Ambulatory Medical Care by David Rutstein; A Clinical Investigator Looks at Medical Education: The Discovery of the Medical Student as a Responsible Colleague by Thomas Hale Ham; The Import of New Discoveries in Medical Practice: Advances in the Diagnosis and Treatment of Infectious Diseases by Harry F. Dowling; The Changing Concepts of Deviance by Douglas D. Bond; The Development of Scientific Medicine by Lester S. King; and The Ethical Problem of Medical Research by Harry K. Beecher.

These essays are of uniformly high quality, informative, and thought-provoking. Each shows a profound historical sense and illustrates that the history of medicine is a vital, helpful tool, not a dry pile of remnants. Every medical student and physician should read this book to get a taste of clear, concise writing, and to savor sound scholarship.

GEORGE E. GIFFORD, JR., M.D.
Instructor in Psychiatry, HMS
Consultant to the Historical Collections, Countway Library

class of 1975

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Bridgeport, Conn. (Yale)

Zaslov, Ricki
Montreal, P. Q., Canada (McGill)

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***Harvard-M.I.T. Program**

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr. Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

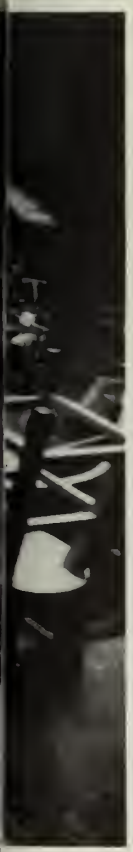
Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

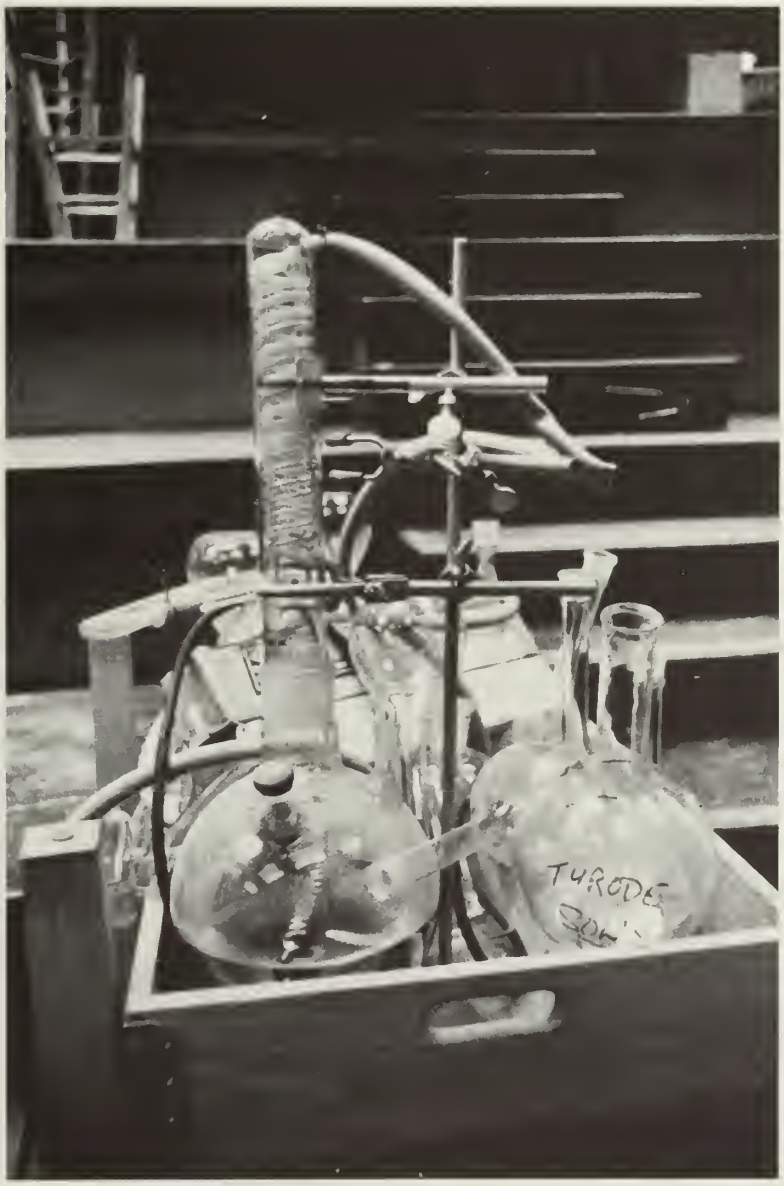
Building D is getting its faee lifted. Aetually the outeome will be a great deal more than eosmetic surgery as extensive renovation and reeonstruetion will be earried out in the Department of Pathology and the Department of Mierobiology and Molecular Geneties.

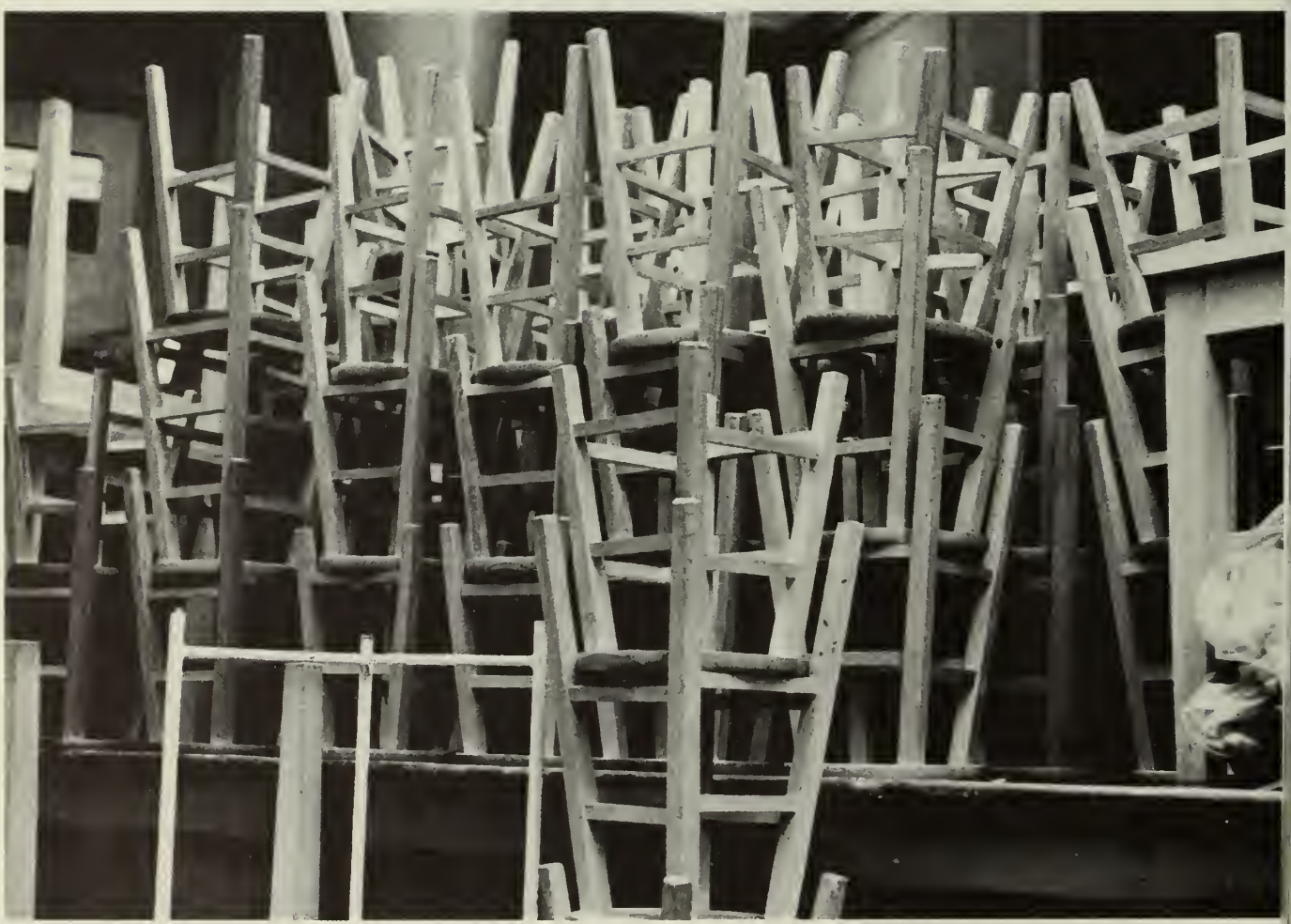
A generous gift of $1.2 million from the Kresge Foundation has been received for renovating the experimental pathology area. Upon eompletion, this section will be named the Kresge Laboratories of Experimental Pathology.

The estimated eost for the total renovation of Building D is $5.2 million. At the present time, there is no federal support available to undertake construetion for primarily scientifie purposes. Therefore, one of the priorities at Harvard Medieal School this year will be to seeure the neeessary funding to eomplete the renovation and reeonstruetion.

Photographer Christopher Morrow was asked to reeord the state of disarray in Amphitheater D. We think he captured the beauty and simplieity of ordered ehaos.







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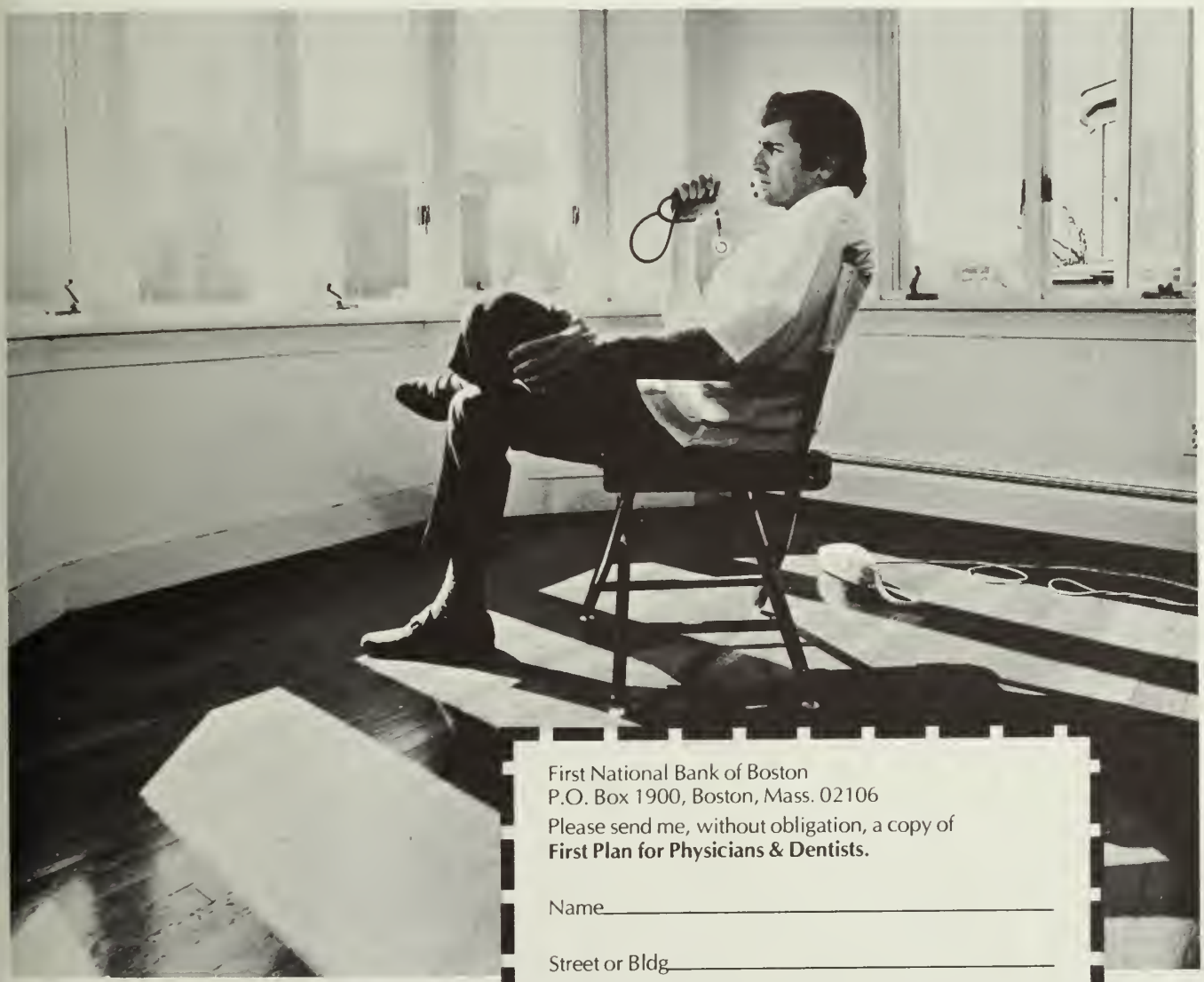

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MARK YOUR CALENDAR

ALUMNI DAY — JUNE 2

CLASS DAY — JUNE 3

ALUMNI NOTES

1918

James B. Shields writes that he has retired.

Elmar S. Waring tells of his reunion house party with 12 grandchildren on Sullivan Island, S.C., "where Poe, who was born on site of Globe Theatre in Boston, wrote and placed the 'Gold Bug.' " He adds: "I don't think any wife in our class, unless possibly Jimmy Lincoln's could have endured it. See you at our 55th in '73."

1923

Julian G. Ely writes that he is still in active general practice.

1928

Leon J. Saul has written two books which were released last spring: *Emotional Maturity* and *Dependence in Man,* with Henry Parens, M.D. This is the third edition of *Emotional Maturity*.

1929

Rupert A. Chittick has retired from practice and spends most of his time on Champlain Island. He will vacation in Florida for a few months this winter. Dr. Chittick continues with his volunteer work at the State Hospital in Waterbury and at the Vermont Association for the Blind.

1930

Henry F. Howe has been appointed a member of the new National Commission on State Workmen's Compensation Laws by President Nixon. The commission will study these laws to determine if they provide adequate and prompt systems of compensation.

1932

Rex S. Campbell is in general practice in surgery.

1933

Charles F. Ferguson was elected historian, editor, and librarian for the American Laryngological Association at its annual meeting in San Francisco in June. Before assuming the presidency of this organization, Dr. Ferguson served as editor of the American Broncho-Esophagological Association.

The *Bulletin* has been informed that **Henry L. Heyl** was honored at an informal dinner that marked his retirement from the Dartmouth medical faculty. Dr. Heyl has been a faculty member of Dartmouth for 29 years, and the faculty and administrative staff of the school paid tribute to him and his dedicated service. Dr. Heyl retains his position as editor of the *Journal of Neurosurgery*.

Hall Seeley writes that he is "enjoying his retirement with gardening, hunting, fishing and traveling."

1934

Richard H. Thompson began a two month volunteer tour of service aboard the hospital ship Hope on September 15th. He will be in Kingston, Jamaica, joining the rest of the staff on a ten-month teaching/treatment mission.

1935

Maxon H. Eddy writes: "Two years of fascinating surgical experience at the Haile Selassie I University Public Health College in Gondar, Ethiopia terminated Sept. 1. Virginia and I spent Sept. and Oct. at the Shants Bhawan Hospital in Kathmandu, Nepal, where I was a volunteer surgeon. Back to Kampala, Uganda to obtain some training in eye surgery and home for